

KY Department for Behavioral Health, Developmental and Intellectual Disabilities
Behavioral Health Targeted Case Management
Curriculum Application Form

This is a general information form that is submitted with all curriculums. This form can be used for submission of one or many (up to five) curriculums.

Reference guide for "Curriculum Type" choices below.

TCM = Targeted Case Management (12 Hour Core TCM)

SED = Severe Emotional Disability (6 Hour Child SED)

SMI = Serious Mental Illness (6 Hour SMI)

CCPHC = Co-occurring Chronic or Complex Physical Health Condition (6 Hour SMI SED SUD CCPHC)

SUD = Substance Use Disorder (6 Hour SUD)

Today's Date: _____

Provider Information

Name of Provider: _____

Mailing Address Line 1: _____

Mailing Address Line 2: _____

City, State, Zip Code: _____

Contact Person

Contact Name: _____

Phone Number: _____

Email Address: _____

First Curriculum

Curriculum Type (check one): ☐ 12 Hour Core TCM ☐ 6 Hour Child SED ☐ 6 Hour SMI
☐ 6 Hour SMI SED SUD CCPHC ☐ 6 Hour SUD

Author of Curriculum

Author Name: _____

Phone Number: _____

Email Address: _____

If the submitting agency chooses to provide a method other than in-person, face to face for the core competencies that allow this option (identified in each curriculum rubric), please select that core competency from the list provided below. NOTE: If you are providing all face-to-face trainings for this curriculum type, you do not need to select from the list below.

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- ☐ 12 Hour TCM Core Comp 9 Developmental Perspectives Across the Life Span
- ☐ 12 TCM Core Comp 10 Documentation - Regulations
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- ☐ 6 Hour SED Core Comp 5 Wraparound Phase 4 Transition
- ☐ 6 Hour SMI Core Comp 4 Transition from Long-Term Care

- ☐ 6 Hour SMI Core Comp 5 Involuntary Commitment and Court Related Outpatient Treatment
- ☐ 6 Hour SUD Core Comp 3 Meeting Facilitation
- ☐ 6 Hour SUD Core Comp 4 Regulations

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Second Curriculum

Curriculum Type (check one): ☐ 12 Hour Core TCM ☐ 6 Hour Child SED ☐ 6 Hour SMI
☐ 6 Hour SMI SED SUD CCPHC ☐ 6 Hour SUD

Author of Curriculum

Author Name: _____

Phone Number: _____

Email Address: _____

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Third Curriculum

Curriculum Type (check one): ☐ 12 Hour Core TCM ☐ 6 Hour Child SED ☐ 6 Hour SMI
☐ 6 Hour SMI SED SUD CCPHC ☐ 6 Hour SUD

Author of Curriculum

Author Name: _____

Phone Number: _____

Email Address: _____

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Fourth Curriculum

Curriculum Type (check one): ☐ 12 Hour Core TCM ☐ 6 Hour Child SED ☐ 6 Hour SMI
☐ 6 Hour SMI SED SUD CCPHC ☐ 6 Hour SUD

Author of Curriculum

Author Name: _____

Phone Number: _____

Email Address: _____

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Fifth Curriculum

Curriculum Type (check one): ☐ 12 Hour Core TCM ☐ 6 Hour Child SED ☐ 6 Hour SMI
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Author of Curriculum

Author Name: _____

Phone Number: _____

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With this form printed, please include:

- 1) USB flash drive with the curriculum(s) saved as a Word or PDF file. (Word preferred.)**
On the USB flash drive, clearly label the flash drive with the provider's name.
- 2) Completed curriculum rubric(s) for the number of curriculums which are being submitted. This can be saved to the USB flash drive as a Word or PDF file. (Word preferred.)**

Thank you.

Submit this information to:

Meg Link

Department for Behavioral Health, Developmental and Intellectual Disabilities

Program Support Branch

275 East Main Street, 4E-C

Frankfort, KY 40621